## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185046	B. WING			12/31/2020	
NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 509 NORTH HAYDEN AVENUE SALEM, KY 42078	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 12/26 12/31/2020. There waidentified with 42 CFF regulations and the fa Centers for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	d Infection Control Survey 8/2020 and concluded on as no deficient practice R 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention It practices to prepare for		TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZI 509 NORTH HAYDEN AVENUE SALEM, KY 42078	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
E 000	Initial Comments		E	000			
	Survey was initiated of concluded on 12/31/2	d Emergency Preparedness on 12/28/2020 and 2020. There was no deficient h 42 CFR 483.73 related to					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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Office of Inspector General

MAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   509 NORTH HAYDEN AVENUE   SALEM SPRINGLAKE HEALTH & REHABILITATION CI   SALEM, KY 42078	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED		
SALEM SPRINGLAKE HEALTH & REHABILITATION CI  (X4) ID PREFIX TAG  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/28/2020 and concluded on 12/31/2020. There was no deficient practice  509 NORTH HAYDEN AVENUE SOM NORTH HAYDEN AVENUE SALEM, KY 42078  ID PREFIX (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)  N 000 N 0	100294			B. WING			12/31/2020		
SALEM SPRINGLAKE HEALTH & REHABILITATION CI  SALEM, KY 42078  (X4) ID PREFIX TAG  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/28/2020 and concluded on 12/31/2020. There was no deficient practice	NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET AD							
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TITLE (X6) DATE